THE MEDICO-LEGAL PROBLEM OF CONSENT IN THE ARMED FORCES

by

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The opinions and conclusions expressed here are those of the individual student author and do not necessarily represent the views of either The Judge Advocate General's School or any other governmental agency. References to this study should include the foregoing statement.

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SCOPE

A study of the medical and legal requirements of consent to medical, dental and surgical treatment, including a discussion of present military practices and policies related to these consent requirements, with conclusions and recommendations.

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CHAPTER I

INTRODUCTION

The subject of this discussion might suggest that there is a problem of great proportions in the armed forces[1] with respect to unauthorized medical treatment, i.e., treatment without the patient's consent. Fortunately, however, such does not appear to be the case. There is not a single reported case since the adoption of the Uniform Code of Military Justice of a serviceman being court-martialed for failing to obey an order to submit to medical treatment, and there are no reported cases holding the United States or a service doctor liable for performing unauthorized treatment.[2] It is possible, however, that some of these latter "incidents" have been settled by means other than litigation.

The general rule is reasonably well established, without the military, that a patient must give his consent before medical treatment can be administered to him. It is the purpose of this discussion to develop and examine

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1. The term "armed forces" is intended to include all the armed forces, however, no direct reference will be made in this study to the Coast Guard since it has no major medical facilities or medical corps. The Public Health Service is primarily responsible for furnishing medical treatment to members of the Coast Guard and their dependents (42 U.S.C. §253) (1944).

2. Coward, Malpractice and the Service Doctor, 9 U.S. Armed Forces Med. J. 224 (1958).

Section I

all aspects of this general rule and to point out those types of situations presenting the greatest legal peril to the service doctor. Consideration is given to pertinent military regulations to determine their effect on the general rule. Finally, certain conclusions and recommendations are submitted dealing with the unique problems generated by having the sick and injured subject to military authority and control.

It is not the purpose of this discussion, unless germane to the text, to consider the nature and extent of the United States' liability for unauthorized treatment under the Federal Tort Claims Act, Military Claims Act, Foreign Claims Act, or other statutes, as this subject has been adequately set forth and analyzed in a number of other writings.[3] Aside from the liability of the United States, it is important for the military practitioner to remember that he is not exempt from individual liability or responsibility merely because he is practicing his

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3. See Marchus, Medical Malpractice, Hospital Negligence and the Armed Services, May 1957 (unpublished thesis presented to The Judge Advocate General's School, U. S. Army); Madden, Malpractice Liability, 13 Med. Bull., U. S. Army, Europe 262 (1956); Rakestraw, Malpractice and the Military Doctor, U. S. Air Force JAG Bull., Nov. 1961, p. 3; Coward, supra note 2.

profession as a member of the armed forces.[4]

The terms "service doctor" and "military practitioner," and all similar designations, are used in this study as a matter of convenience to include all those persons in the armed forces responsible for administering medical, dental, or surgical treatment; e.g., physicians, surgeons, osteopaths, dentists, nurses, and corpsmen. The term "medical treatment," unless otherwise indicated, is also used as a matter of convenience to include medical, dental, and surgical treatment.

UNAUTHORIZED TREATMENT AS A FORM OF MALPRACTICE

The subject of "malpractice in the military" is a very broad one indeed, involving an almost innumerable list of legal aspects arising while the relationship of doctor and patient exists. The general subject has been "treated" by several writers.[5] Ordinarily the term "malpractice" is associated with the term "negligence," i.e., the practitioner's failure to comply with the standard of conduct established by the reasonable and ordinary practice of practitioners in the same general locality.[6] It is

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4. See Madden, op. cit. supra note 3; Winthrop, Military Law and Precedents, p. 885 (2d ed. 1920).

5. Coward, op. cit. supra note 2; Marchus, Madden, Rakestraw, op. cit. supra note 3.

6. Prosser, Torts §31 (2d ed. 1955); 41 Am. Jur. Physicians and Surgeons §82 (1942); Sinz v. Owens, 33 Cal.2d 749, 753, 206 P.2d 3, 5 (1949).

this form of malpractice that is most often litigated in the courts and is usually the greatest concern to the medical profession.

This discussion, however, focuses on another type of malpractice - unauthorized medical treatment, i.e., treatment performed without the express or implied consent of the patient. Such treatment constitutes an assault and battery[7] which may subject the practitioner to criminal prosecution[8] or render him civilly liable for damages. The court in Physicians' and Dentists' Business Bureau v. Dray[9] related unauthorized treatment to malpractice in the following language:

> While an unauthorized operation is, in contemplation of law, an assault and battery, it also amounts to malpractice, even though negligence is not charged. Herzog, Medical Jurisprudence, 153, §180, defines malpractice as follows: "Malpractice, also sometimes called 'malapraxis,' means bad or unskilled practice, resulting in injury to the patient,

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7. A few courts, representing a small minority, have held that unauthorized treatment is not distinguishable from other forms of malpractice and, therefore, constitutes "negligence." See, e.g., Wellman v. Drake, 130 W.Va. 229, 43 S.E.2d 57 (1947); Hershey v. Peake, 115 Kan. 562, 223 Pac. 1113 (1924).

8. See State v. Gile, 8 Wash. 12, 35 Pac. 417 (1894); Winthrop, Digest of Opinions of the Judge Advocates General, p. 54 (Rev.ed. 1901); Hirsch, Consent To Medical Treatment - With Forms, Trial Lawyer's Guide, Aug. 1961, p. 123.

9. 8 Wash.2d 38, 40, 111 P.2d 568, 569 (1941) (Emphasis in original.)

and comprises all acts and omissions of a physician or surgeon as such to a patient as such, which may make the physician or surgeon either civilly or criminally liable."

The Legal Significance of Assault and Battery Classification

The classification of the action for unauthorized treatment as one of assault and battery rather than as an action of negligence has several legal consequences. The most important of these consequences are:

First. In an action for negligence the doctor would be able to rely upon expert testimony to the effect that he had in fact complied with the standard of care normally exercised by reasonable doctors under like circumstances, whereas in an action for assault and battery, the doctor could not rely upon expert testimony since the only issue is whether the patient consented.[10]

Second. The plaintiff in an action for assault and battery need not show any physical injury to establish

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10. The plaintiff in a malpractice case generally has a very difficult time in obtaining expert testimony favorable to his cause. See, e.g., Grist v. French, 136 Cal.App.2d 247, 258, 288 P.2d 1003, 1010 (1955); Huffman v. Lindquist, 37 Cal.2d 465, 483, 234 P.2d 34, 46 (1951) (dissenting opinion by Carter, J.). For a discussion of the reasons why doctors are reluctant to testify see, McCoid, A Reappraisal of Liability for Unauthorized Medical Treatment, 41 Minn. L. Rev. 381, 432-33 (1957).

[illegible]

damages, whereas in an action for negligence the plaintiff would have to prove actual damages.[11]

Third. The plaintiff in an action for assault and battery is more likely to recover exemplary or punitive damages than in an action for negligence.[12]

Fourth. An action for assault and battery generally has a shorter statute of limitations than an action for negligent malpractice. This is the main reason a few courts have held that unauthorized treatment amounts to negligence rather than assault and battery.[13]

Fifth. Possibly the greatest potential unfavorable consequence to the plaintiff "assaulted" by a service doctor is the effect that such classification has on a suit brought under the Federal Tort Claims Act. Assault and battery actions are specifically excluded from the act[14] which means a patient cannot recover in such an action against the Government. The only recourse left to such a patient would be an action against the doctor as an individual or to seek relief through private relief legislation.

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11. Restatement, Torts §18 (1934).

12. Prosser, Torts 9-10 (2d ed. 1955).

13. See, e.g. Hershey v. Peake, supra note 7; McClees v. Cohen, 158 Md. 60, 148 Atl. 124 (1930); Physicians' and Dentists' Business Bureau v. Gray, 8 Wash.2d 38, 111 P.2d 568 (1941).

14. 28 U.S.C. §2680 (h) (1952).

[illegible]

In Moss v. United States,[15] a plaintiff was denied recovery where his right leg (when the operation was planned for his left leg) was amputated without his consent while he was a patient in a Veteran's Hospital. The court stated, "It does not appear that the words 'assault and battery' as found in 28 U.S.C.A. §2680 (h) have such a narrow or restricted scope as to exclude the performance of such surgical operation . . . . The section is not limited to intentional or violent torts."[16] The result, however, would be different in those few jurisdictions[17] where unauthorized treatment is held to constitute negligence rather than assault and battery as the Federal Tort Claims Act does not exclude "negligence."

THE UNDERLYING REASON FOR THE CONSENT REQUIREMENT

The underlying reason behind the legal requirement that a medical practitioner must have the consent of a patient before treatment is administered stems from the "natural right of the individual." The court in Rolater v. Strain,[18] quoted approvingly from 37 Chicago Legal News,

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15. 118 F.Supp. 275 (D. Minn. 1954), aff'd, 225 F.2d 705 (8th Cir. 1955).

16. Id. at 276-77.

17. See notes 7 and 13, supra.

18. 39 Okla. 572, 137 Pac. 96 (1913).

p. 213 as follows:

> "Under a free government at least, the free citizen's first and greatest right, which underlies all others--the right to the inviolability of his person, in other words, his right to himself -- is the subject of universal acquiescence, and this right necessarily forbids a physician or surgeon, however skillful or eminent, who has been asked to examine, diagnose, advise and prescribe . . ., to violate without permission the bodily integrity of his patient by a major or capital operation, placing him under anaesthetic for that purpose, and operating on him without his consent or knowledge."[19]

Judge Cardozo speaking for the court in Schloendorff v. Society of New York Hospital[20] expressed the view:

> Every human being of adult years and sound mind has a right to determine what shall be done with his body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.

Chief Judge Quinn of the United States Court of Military Appeals in a criminal case, where the issue was the admissibility of an analysis of urine extracted from an unconscious suspect, made this observation:

> The entire genius of our American institutions, the guarantees of the Bill of Rights, the protections of the Uniform Code of Military Justice, all combine to establish the truth of the aphorism "that a man's home is his castle." A fortiori then, these inalienable rights, which are implicit in the Law of Nature, and of Nature's God, demand that the sanctity of the human body, made in the image and likeness of God--the temple of his immortal soul--be and remain forever sacred and inviolate.[21]

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19. Id. at 575, 137 Pac. at 97.

20. 211 N.Y. 125, 129-130, 105 N.E. 92, 93 (1914).

21. United States v. Williamson, 4 USCMA 320, 335, 15 CMR 320, 335 (1954) (dissenting opinion).

There are many situations, of course, where these "natural rights" must give way to a rule of reason and touchings are permitted without the consent of the person touched, e.g., when an officer makes an arrest.[22]

THE LEGAL EFFECT OF ACQUIRING CONSENT

Consent will ordinarily avoid liability for intentional interference with the person. Consent is not strictly speaking, a privilege, or even a defense, but goes to negative the very existence of any tort. Dean Prosser expresses the general effect of consent in the following terms:

> It is a fundamental principle of the common law that volenti non fit injuria -- to one who consents, no wrong is done. The attitude of the courts has not been one of paternalism. Where no public interest is involved, they have left the individual to work out his own destiny, and are not concerned with protecting him from his own folly in permitting others to damage him . . . . As to intentional invasions of the plaintiff's interests, his consent negatives the wrongful element of the defendant's act, and prevents the existence of a tort. "The absence of lawful consent", said Mr. Justice Holmes, "is part of the definition of an assault."[23]

It should be noted at this point, although the proposition is fully explored later in the discussion, that consent of the patient does not always give the doctor a license to act.

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22. See Restatement, Torts §13 (1934).

23. Prosser, Torts 82 (2d ed. 1955).

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CHAPTER II

REQUIREMENTS FOR LAWFUL CONSENT

GENERALLY

Lawful consent to medical treatment must be given expressly by the patient or by someone authorized to act in his behalf, or implied from the facts or circumstances; it may be either written or oral. Under certain conditions, the consent must be "informed," i.e., the patient must have an understanding of the proposed treatment and the risks involved. The law also requires that the patient have the legal capacity to consent. The law provides for the satisfaction of all these requirements in an emergency, and the law disregards these requirements when public policy demands certain treatment.

Consent, although expressly given, might be defective because it was "uninformed"; or was obtained as a result of fraud, mistake, coercion, minority, insanity; or the treatment was illegal *per se*.

It is not the purpose of this chapter to set forth an exhaustive listing of the almost infinite number of cases touching upon the problem of consent. Only landmark cases and those giving direction or pointing to future trends are included.

It is very difficult to characterize and label even

the selected cases because of the varied factual situations giving rise to them. However, some classification is necessary to an orderly treatment. It is hoped that the author's selection of headings will prove useful in understanding the rules. The phrase "express instructions," as subsequently used, means situations where the patient has set forth, or has given express consent that amounts to, a definite and explicit mandate to do a certain thing and no more or not to do a specific thing.

TREATMENT ACCORDING TO EXPRESS INSTRUCTIONS - EXPRESS CONSENT

A competent, adult patient has a right to expressly prohibit or limit medical treatment even if the treatment is necessary to preserve life, limb, or health.[24] This means that short of suicide or an attempted suicide a competent, adult person has an inherent right to die or suffer in peace without treatment being forced upon him. The practitioner is bound to honor this right and failure to so honor, as already indicated, would constitute an assault and battery; as a corollary to this rule a practitioner would not be held legally accountable for failing to treat such a patient even though his action might be criticized on moral grounds

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24. Authority for this rule will be found in the discussion under the heading "The Underlying Reason for the Consent Requirement," pages 5-6, supra.

or by his professional associates.[25] A person who is a minor or incompetent lacks the legal capacity to consent, therefore, the express instructions of such a patient would not be legally binding upon one who administers treatment.[26]

Two very famous cases, Jacobson v. Massachusetts[27] and Buck v. Bell,[28] have established the rule that express instructions may be disregarded if the treatment is compelled by a valid statute. Such statutes are generally directed to both practitioners and patients and both are legally responsible for complying with their provisions. It has also been held that prostitutes may be examined against their wishes to determine if they have a venereal disease.[29]

The most oft-cited case of express prohibition to treatment is Schloendorff v. Society of New York Hospital.[30]

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25. See, e.g., Childers v. Frye, 201 N.C. 39, 42, 158 S.E. 742, 744 (1931).

26. See, e.g., Farber v. Olkon, 40 Cal.2d 503, 254 P.2d 520 (1953); Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906).

27. 197 U. S. 11 (1905) (compulsory vaccination).

28. 274 U. S. 200 (1929) (compulsory sterilization).

29. Laux v. Stitt, 186 Wash. 180, 57 P.2d 321 (1936).

30. 211 N.Y. 125, 105 N.E. 92 (1914).

Mary Schloendorff entered the defendant hospital for the purpose of being examined under anaesthetic to determine the nature of a lump in her stomach. She claimed that she had notified the doctor, "that there must be no operation." While under anaesthetic, a fibroid tumor[31] was removed from her abdomen and as a result, according to a witness, "gangrene developed in her left arm, some of her fingers had to be amputated, and her sufferings were intense." The court denied recovery against the charitable hospital on the basis that no master-servant relationship existed between it and the personnel responsible for the treatment; however, the court stated that the action of the surgeon was actionable: "In the case at hand, the wrong complained of is not merely negligence. It is trespass . . . a surgeon who performs an operation without his patient's consent, commits an assault for which he is liable in damages."[32]

The leading Canadian case of treatment contrary to express instructions is Mulloy v. Hop Sang.[33] The plaintiff,[34]

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31. A tumor made up of fibrous and muscular tissue.

32. Schloendorff v. Society of New York Hospital, supra note 30, at 129-130, 105 N.E. at 93-94.

33. [1935] 1 West. Weekly R. 714 (Sup. Ct. Alberta).

34. The plaintiff, Dr. J. K. Mulloy, is the father-in-law of the author.

a physician and surgeon, was called to the hospital to treat defendant's hand which had been badly injured in an automobile accident. The defendant, a stranger and unacquainted with the plaintiff, "asked him [the plaintiff] to fix up his hand but not to cut it off as he wanted to have it looked after in Lethbridge, his home city." Before anaesthetic had been administered, the defendant repeated his request that he did not want his hand cut off. "The doctor, being more concerned in relieving the suffering of the patient, replied that he would be governed by the conditions found when the anaesthetic had been administered." An examination of the hand could not be carried out while the patient was conscious because the hand was covered by an old piece of cloth that couldn't be removed without severe pain. Two attending physicians agreed with the plaintiff, after anaesthetic was given and an examination made, that the "condition of the hand was such that delay would mean blood poisoning with no possibility of saving it." The plaintiff amputated the hand and later brought action for his professional fee. The defendant filed a cross-action for the cost of an artificial hand, loss of wages, and general damages. The court, after expressing the opinion that "the operation was necessary and performed in a highly satisfactory manner," denied recovery to the plaintiff because the operation was unauthorized and

amounted to a trespass to the person of the defendant. In summing up the court stated that the defendant's, "damages, should . . . be substantial but only sufficient to make them substantial rather than nominal. I place the amount at $50." Recovery for the cost of an artificial hand was denied on the grounds that the cost was a result of the accident and not the unauthorized operation.

A similar case arose when Mattie I. Strain went to Dr. Bolater for treatment of an infected foot.[35] She gave him express instructions not to remove any bones. While she was under anaesthetic the surgeon removed a small sesamoid bone[36] to aid the drainage of the infection. The court held that the doctor committed an actionable wrong by acting contrary to specific directions. An interesting issue in the case concerned whether the patient was actually injured by the removal of the unnamed sesamoid bone. Dr. Bolater contended that since the bone served no useful function the patient should receive no more than nominal damages. The appellate court rejected this argument and

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35. Bolater v. Strain, 39 Okla. 572, 137 Pac. 96 (1913).

36. Taber's, Cyclopedic Medical Dictionary S-42 (5th ed. 1951) defines "sesamoid bone" as follows: "An oval nodule of bone or fibrocartilage in a tendon playing over a bony surface."

approved damages of $1000 stating that:

> [The jury] Being composed of men of ordinary intelligence, may have consulted their common experience, and reached the conclusion that every bone in the human body serves some useful purpose, and that the sesamoid bone in the plaintiff's foot served a purpose, and its removal might have resulted in injury, the testimony of the experts to the contrary notwithstanding . . . . From the evidence, the jury might have found that the removal of the sesamoid bone was in a measure responsible for these unfavorable conditions.[37]

Treatment should always be rendered according to the patient's last instructions, assuming, of course, that the patient in the first instance could give legally binding instructions and is competent when the subsequent instructions are given. This rule is best illustrated by the case of Bakewell v. Kable.[38] The plaintiff in this case alleged that the defendant, a chiropractor, had made an erroneous diagnosis of her ailment and suggested that certain "adjustments" be made. The plaintiff initially expressly consented to having the adjustments made. However, after the treatment had commenced, the plaintiff shouted, "Oh, that was awful . . . . Let me up. I don't want anymore; I can't stand anymore."[39]

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37. Bolater v. Strain, supra note 35, at 580, 137 Pac. at 99.

38. 125 Mont. 89, 232 P.2d 127 (1951).

39. Id. at 91, 232 P.2d at 128.

30. Id. at 91, 132 A.2d at 321.

31. 158 Conn. 79, 256 A.2d 170 (1969).

32. Bolduc v. Gorrell, 158 Conn. at 86, 256 A.2d at 174.

The defendant ignored these last instructions and continued making adjustments which resulted in the alleged injuries. The appellate court approved judgment for the plaintiff on the grounds that treatment, continued after the plaintiff's last instructions, was unauthorized and amounted to an assault. The court also held that this amounted to malpractice even though there was no negligence charged.

TREATMENT WITHOUT EXPRESS INSTRUCTIONS - IMPLIED CONSENT

It is quite obvious that situations will develop in which it is impracticable or impossible to obtain express instructions from a patient or anyone legally authorized to assume such responsibility; therefore, if authorization is to be bound for the treatment, it must be implied from the circumstances. The courts and writers frequently employ the terms "implied in fact"[40] and "implied in law"[41] in discussing cases where there are no express instructions. A distinction is not attempted by this author as it is not deemed important to the body of this discussion.

Emergency Treatment

The most important exception to the general rule that consent must be obtained prior to treatment is found in

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40. See, e.g., McGuire v. Rix, 118 Neb. 434, 225 N.W. 120 (1929).

41. See, e.g., Luka v. Lowrie, 171 Mich. 122, 136 N.W. 1106 (1912).

those emergency situations where the patient is unable physically or legally to give binding instructions, e.g., he is unconscious or a minor and is in need of prompt medical attention. In an emergency situation a practitioner may render his services according to his best judgment without instructions from anyone and without incurring liability for an assault and battery.[42]

What is an "emergency" is a question upon which the courts have varying opinions, therefore, a few of the most illustrative and most frequently cited cases will be discussed before a definition will be attempted.

There are two ways in which most emergencies arise: (1) due to unforseen results or discoveries occurring after treatment, usually surgery, has begun; or (2) as a result of an accident. The former only arose with the advent of anaesthetic and could not have been envisioned when the common-law rule regarding consent to treatment was being formulated. Medical treatment, including surgical operations, was performed in the patient's home before anaesthetic came into use. Patients were usually conscious and doctors could freely ask them for instructions. In those cases where the patient lapsed into unconsciousness, immediate members of the family were close at hand to

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42. Authority for this rule is found in the discussion, infra.

give the needed instructions; "Hence the court formulated the rule that any extension of the operation by the physician without the consent of the patient or someone authorized to speak for him constituted a battery or trespass upon the person of the patient for which the physician was liable in damages."[43]

The need for a more enlightened view was apparent and it would be difficult indeed for the author to express this need more succinctly than did the court in Bennan v. Parsonnet:[44]

> The surgical employment of anaesthesia has, as a matter of common knowledge, not only eliminated the possibility of obtaining the patient's consent during the operation, but has also had other medical effects of which notice must be taken. Thus it has rendered possible and of everyday occurrence surgical operations of a character and magnitude not dreamed of at the time the common law was in the making, and, as a matter of practical moment, has also advanced the period that marks the commencement of a surgical operation from the time when the patient's body is actually invaded by the knife to the time when the anaesthetic is administered, or at least when the patient has succumbed to its influence. The employment of anaesthesia has also postponed to this same period of relaxation and unconsciousness the making of that complete and final diagnosis of the patient's condition that at common law was made at a time when he could be both informed and consulted. By these considerations the scope of modern surgical operations has been greatly enlarged, and the legal rule applicable thereto extended beyond the actual emergencies of actual surgery to other matters more or less vitally affecting the patient's welfare. To meet these changed conditions, the rule of law

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43. Kennedy v. Parrott, 243 N.C. 355, 364, 90 S.E.2d 754, 758 (1956).

44. 83 N.J.L. 20, 23-24, 83 Atl. 948, 949-950 (1912).

> must, in the interest alike of the patient and the surgeon, be adapted to the changes that have been so wrought, chief among which is the unconscious state of the patient at a time when by the common law rule his consent must be obtained.

How far have the courts dared to go in permitting treatment without consent in emergency situations?

The case most often cited as authority for the emergency rule is Mohr v. Williams.[45] The Minnesota Supreme Court expressed the rule this way:

> If a person should be injured to the extent of rendering him unconscious, and his injuries were of such a nature as to require prompt surgical attention, a physician called to attend him would be justified in applying such medical or surgical treatment as might reasonably be necessary for the preservation of his life or limb, and consent on the part of the injured person would be implied. And again, if, in the course of an operation to which the patient consented the physician should discover conditions not anticipated before the operation was commenced, and which if not removed, would endanger the life or health of the patient, he would though no express consent was obtained or given, be justified in extending the operation to remove and overcome them.[46]

The court went on to hold that the following facts did not justify the treatment. The plaintiff came to Dr. Williams complaining of difficulty with her right ear and after an examination the plaintiff consented to an operation on that ear. After the plaintiff had been anaesthetized, the defendant surgeon found a serious condition to exist in the plaintiff's left ear which was not detectable during

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45. 95 Minn. 261, 104 N.W. 12 (1905).

46. Id. at 269, 104 N.W. at 15.

the prior examination because of an obstruction. The defendant performed an ossiculectomy[47] after reaching an agreement with the plaintiff's family physician that such an operation should be performed. The court reasoned that the urgency was insufficient to permit treatment without express instructions. It made not a whit of difference that the operation was skillfully performed and was beneficial to the patient. The treatment amounted to an assault and battery.

In King v. Carney,[48] the plaintiff came to the defendant asking "to be fixed so I can bear children . . . ." Thereupon the defendant made a physical examination and recommended an operation. The plaintiff expressly consented to the recommended operation. The defendant upon discovering diseased ovaries and Fallopian tubes extended the operation to provide for their removal. The defendant, and another doctor who assisted with the operation, testified that it was necessary to remove the diseased organs in order to preserve the plaintiff's life and health, and it would have been dangerous to her life and health not to do so. The court in holding for the defendant stated:

> If in the course of an operation to which the patient consented the physician should discover conditions not anticipated before the operation was commenced, and which, if not removed, would

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47. Excision of a small bone from the ear.

48. 85 Okal. 62, 204 Pac. 270 (1922).

> endanger the life or health of the patient, he would, though no express consent was obtained or given, be justified in extending the operation to remove and overcome them . . . innumerable cases from other jurisdictions are collated wherein the same principle is recognized.[49]

The result was different in a more recent "Fallopian tube" case.[50] Macine Tabor, a minor twenty years of age, agreed to an appendectomy that was to be performed by the defendant. During the operation the surgeon discovered that the plaintiff's Fallopian tubes were full of pus, swollen, and sealed at both ends. The defendant proceeded to remove the tubes because they would have had to come out "within six months anyway if I was not mistaken." The defendant was supported by expert testimony to the effect that there was a danger of the tubes breaking and causing peritonitis.[51] The defendant didn't receive express consent from anyone even though the patient's stepmother was in the hospital at the time. In holding for the plaintiff the court stated:

> The evidence offered does not justify the conclusion as a matter of law that there existed an emergency of such <u>immediate</u> urgency as to justify the removal of the tubes without the consent of the patient or her stepmother. The evidence indicated that removal of the tubes probably would be necessary soon, that their remaining in the body in their swollen and infected condition was dangerous, but it did not

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49. Id. at 64, 204 Pac. at 272.

50. Tabor v. Scobee, 254 S.W. 2d 474 (Ky. 1951).

51. Inflammation of a particular area of the abdominal cavity.

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> establish that their removal was an emergency in the sense that death would likely ensue immediately if the tubes were not removed . . . . Although delay in their removal might have proved harmful, even fatal, there was still time to give the parent and the patient the opportunity to weigh the fateful question.[52]

In Moss v. Richworth,[53] the defendant surgeon removed the diseased tonsils and adenoids of an eleven year old child without the consent of a parent or the child, however, an adult sister did give permission. The child died as a result of the anaesthetic. The parent was unsuccessful in recovering damages in the trial court, but the case was reversed on appeal. The appellate court held:

> The evidence shows that there was an absolute necessity for a prompt operation, but not emergent in the sense that death would likely result immediately upon failure to perform it. In fact, it is not contended that any real danger would have resulted to the child had time been taken to consult the parent with reference to the operation. Therefore, the operation was not justified upon the ground that an emergency existed.[54]

An accident type emergency was dealt with in Luka v. Lowrie.[55] A fifteen year old boy fell under the wheels of a train and his left foot was crushed. He was taken to a hospital and shortly after arriving he lapsed into complete unconsciousness. After consulting four house

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52. Tabor v. Scobee, supra note 50, at 476-477.

53. 222 S.W. 225 (Tex. 1920). This action was commenced prior to 1913; see 59 S.W. 122 (1913) and 191 S.W. 843 (1917).

54. Id. at 226. (Emphasis supplied.)

55. 171 Mich. 122, 136 N.W. 1106 (1912).

physicians, the defendant surgeon amputated the boy's injured foot. It was agreed by all the physicians that an immediate amputation was necessary to save the boy's life. No express instructions were received from anyone. The court held for the defendant due to the emergency nature of the treatment.

> The fact that surgeons are called upon daily, in all our large cities, to operate instantly in emergency cases in order that life may be preserved, should be considered. Many small children are injured upon the streets in large cities. To hold that a surgeon must wait until perhaps he may be able to receive the consent of the parents before giving to the injured one the benefit of his skill and learning, to the end that life may be preserved, would, we believe, result in the loss of many lives which might otherwise be saved. It is not to be presumed that competent surgeons will wantonly operate, nor will they fail to obtain the consent of parents to operations where such consent may be reasonably obtained in view of the exigency.[56]

Another case involving an accident emergency is Jackovach v. Yocom.[57] A seventeen year old plaintiff was involved in an accident while riding on a freight train. The defendant was called to the scene a few minutes after the accident and found the plaintiff suffering from serious head injuries and a crushed arm. The doctor took the plaintiff to his office where he tried to contact his parents who lived some ten miles distant. Two other

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56. Id. at 135, 136 N.W. at 1110, 1111.

57. 212 Iowa 914, 237 N.W. 444 (1931).

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physicians were called in to assist the defendant, and all agreed that the arm should be amputated, whereupon it was. The plaintiff later sued the defendant surgeon for performing the operation without consent; it was also alleged that the operation was unnecessary. The court is holding that the emergency justified the defendant's action stated:

> While the courts are not entirely in harmony upon the question of consent to an operation, we think the better reasoning supports the proposition that, if a surgeon is confronted with an emergency which endangers the life or health of the patient, it is his duty to do what the occasion demands within the usual and customary practice among physicians and surgeons in the same or similar localities, without the consent of the patient.[58]

In Pratt v. Davis,[59] where the defendant allegedly removed the plaintiff's uterus without her consent, the court stated as a general proposition of law:

> Where the patient desires or consents that an operation be performed, and unexpected conditions develop or are discovered in the course of the operation, it is the duty of the surgeon, in dealing with these conditions, to act on his own discretion, making the highest use of his skill and ability to meet the exigencies which confront him, and in the nature of things he must frequently do this without consultation or conference with anyone, except, perhaps, other members of his profession who are assisting him. Emergencies arise, and when a surgeon is called it is sometimes found that some action must be taken immediately for the preservation of the life and health of the patient, where it is impracticable to obtain

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58. Id. at 925, 237 N.W. at 449. (Emphasis supplied.)

59. 224 Ill. 300, 79 N.E. 562 (1906).

> the consent of the ailing or injured one or of any one authorized to speak for him. In such event, the surgeon may lawfully, and it is his duty to, perform such operation as good surgery demands, without such consent.[60]

What is an emergency? Two of the cited cases[61] would restrict the emergency exception to those situations where "death would likely ensue (result) immediately" if such treatment were not performed. This is an extreme view and was probably applied in the Tabor case because the treatment involved the organs of reproduction. No explanation is offered for the language in the Moss case as such language was unnecessary to reach the holding, i.e., the court could have held for the plaintiff using the language of the holding in Mohr v. Williams.[62] The author concludes from the foregoing that except in those few jurisdictions applying the strict rule set forth in Tabor and Moss, the practitioner can rely on the definition that follows, in determining if he should act without express instructions or wait until such instructions are received. An emergency exists in those situations where the patient is in need of prompt medical treatment for the protection of his life, or to prevent serious impairment to health or limb and is unable to give express instructions to the practitioner because of unconsciousness,

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60. Id. at 309, 310, 79 N.E. at 565. (Emphasis supplied.)

61. Tabor v. Scobee, supra note 50 and Moss v. Richwerth, supra page 23.

62. Discussed on pages 20-21, supra.

insanity, intoxication or some other physical or legal incapacity, and there is no legal representative reasonably available who could give legally effective instructions on his behalf.

In justifying the practitioner's action the courts often employ the fiction of implied consent. The court in the Bonan case[63] went so far as to suggest ". . . it is imperative that the law shall in his [patient's] interest raise up some one to act for him . . .,"[64] and recommended as a solution that the law should cast the responsibility on the practitioner because by legal implication "the patient intended him to act for him when he made no other selection."[65]

Several of the above quotes state that the practitioner would be "justified" in rendering emergency care; would the practitioner be justified in not rendering such care? The Jackovach[66] and Pratt[67] cases express the view that

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63. Note 44, supra.

64. 83 N.J.L. 20, 24, 83 Atl. 948, 950 (1912).

65. Ibid.

66. Discussed on pages 24-25, supra.

67. Discussed on pages 25-26, supra.

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63. Ibid. 66, 1933.

64. Ibid. 67, 1933.

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766. Ibid. 768, 1933.

767. Ibid. 769, 1933.

768. Ibid. 770, 1933.

769. Ibid. 771, 1933.

770. Ibid. 772, 1933.

771. Ibid. 773, 1933.

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773. Ibid. 775, 1933.

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788. Ibid. 790, 1933.

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996. Ibid. 998, 1933.

997. Ibid. 999, 1933.

998. Ibid. 1000, 1933.

999. Ibid. 1001, 1933.

1000. Ibid. 1002, 1933.

the practitioner has a "duty" to act in an emergency. One recent case seems to make this a legally enforceable duty. In Kolesar v. United States,[68] the patient had a cardiac arrest during the course of an abdominal operation. The court held that in such a situation the surgeon was negligent in failing to perform a thoracotomy[69] and manual cardiac massage in time to prevent brain injury to the patient where such a procedure was practiced in the area where the hospital was located. The court in effect stated that in such an emergency the surgeon owes a duty to the patient to perform the necessary additional operation, and a failure to carry out this duty amounts to negligence. Precedent is lacking for holding a practitioner liable for refusing to treat a person, who is not the patient of the practitioner, in an emergency.[70]

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68. 198 F.Supp. 517 (S.D. Fla. 1961).

69. Surgical incision of the chest wall.

70. The position of the American Medical Association on this issue is set forth in Opinions and Reports of the Judicial Council, A.M.A., p. 27 (1960 ed.) as follows: "A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service."

Non-Emergency Treatment

The most frequent application of the doctrine of implied consent occurs when a patient is treated by a doctor during a routine office call. The patient usually walks in and explains the nature of his ailment, and the doctor proceeds to make an examination. This examination most often requires a touching and seldom will the doctor ask, "do you consent to this touching"? Such a touching would not amount to a battery as the patient by submitting to the examination has by implication given his consent. The court in State v. Housekeeper[71] stated, "If the plaintiff alleges that there was no consent, he must establish his affirmation by proof. The party who allows a surgical operation to be performed is presumed to have employed the surgeon for that particular purpose." Accordingly the following charge was expressly approved in Knowles v. Blue,[72] where a skin graft was taken from the plaintiff's leg allegedly without his consent:

> I charge you that, if plaintiff voluntarily submitted to the operation -- that is, knew it was about to be performed, and made no objection -- his consent is to be presumed, unless he was the victim of a false and fraudulent representation; this last a fact to be made reasonably clear by the evidence.

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71. 70 Md. 162, 170-171, 16 Atl. 382, 384 (1889).

72. 209 Ala. 27, 29, 95 So. 481, 483 (1923).

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77. 78 Fd. 162, 170-171, 14 Ill. 2d 9, 149 (1958).

In McGuire v. Rix,[73] consent to set a fracture by surgery was held to be implied where the plaintiff with a broken ankle bone willingly accompanied the doctor to the hospital for the purpose of having the fracture reduced and was voluntarily placed under anaesthetic for that purpose.

It has also been held that general instructions by a patient to his surgeon authorizing him to operate for the cure of a specific physical condition, not only authorizes such operation, but also authorizes the surgeon, "by clear implication," to diagnose the case to ascertain for himself the exact cause of the patient's ailment and to make preliminary exploratory incisions which may be necessary for that purpose.[74]

In Moore v. Webb,[75] the court held that going to the office of one dentist on the advice of another dentist did not imply authority for the former to extract eight teeth while the patient was under anaesthetic and hadn't given express instructions concerning their removal.

In Hall v. United States,[76] an Army sergeant's wife entered a naval hospital as a military dependent for prenatal care. The evidence established that there was no specific consent by her to the use of a spinal anaesthetic,

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73. 118 Neb. 434, 225 N.W. 120 (1929).

74. King v. Carney note 48, supra.

75. 345 S.W.2d 239 (Mo. 1961).

76. 136 F.Supp. 187 (W.D. La. 1955).

however, she entered the hospital for the express purpose of giving birth and such birth was imminent upon admission. Under these circumstances the court found that the plaintiff impliedly consented to the administration of the anaesthetic.

CHAPTER III

DEFECTIVE CONSENT

It has been shown that a practitioner, in the absence of an emergency, must have the express or implied consent of a patient or of someone authorized to speak on his behalf, before treatment can be lawfully administered to him. However, merely because a patient gives general consent or signs a consent form doesn't mean that the doctor has fulfilled all of his duties to his patient. The practitioner always has the duty of seeing that the patient's consent is not defective, i.e., it was informed and was not brought about by coercion, fraud, mistake, or incapacity.

UNINFORMED CONSENT

A recent trend of the cases makes it evident that, to be legally valid, consent to medical treatment must be an intelligent, informed consent with an understanding of what is to be done and the risks involved.[77] Uninformed consent is defective consent. The underlying reason for the consent requirement was said to be the right of a person "to determine what shall be done with his body."[78] If a doctor treated a patient on the basis of facts known

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77. Although the recent cases have shown a definite trend toward requiring a more informed consent, the concept itself is an old one; see, e.g., Hunter v. Burroughs, 123 Va. 113, 96 S.E. 360 (1918).

78. Schloendorff v. Society of New York Hospital, supra page 8.

only to the doctor, it would be the doctor and not the patient who would be deciding what should be done with the patient's body.

A dilemma is created for the practitioner where a disclosure of all the facts might cause injury to the patient or aggravate an existing condition. This was definitely recognized in Salgo v. Leland Stanford Jr. University Board of Trustees[79] where the court expressed the view:

> A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known degrees of a procedure or operation in order to induce his patient's consent. At the same time, the physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action. One is to explain to the patient every risk attendant upon any surgical procedure of operation, no matter how remote. This may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of the physiological result of the apprehension itself. The other is to recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed, consistent with the full disclosure of facts necessary to an informed consent.[80]

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79. 154 Cal.App.2d 560, 317 P.2d 170 (1957).

80. Id. at 578, 317 P.2d at 181.

only to one extent, if [illegible] the attorney and not the
parties who would be benefited, will insure to those with the
patience to wait.

[illegible] is granted for the admissibility under a
declaration of all the facts which might serve injury to the
patient's reputation or mutually confidence. This was
decidedly recognized in [illegible] v. [illegible]
Supreme Court of Tennessee[79] where the court declared
the rule:

[illegible]

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79. [illegible]

80. [illegible]

This discussion will be limited to a consideration of the legal precedent as reported in the cases and will not attempt to cover the "ought" or moral considerations inherent in the problem.[81]

In Bang v. Charles T. Miller Hospital,[82] the plaintiff gave his consent to the defendant surgeon to perform a transurethral prostatic resection.[83] During the course of the operation his spermatic cord was severed, rendering him sterile. It was the plaintiff's contention that nothing had

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81. For a discussion of the moral viewpoint see Fletcher, Morals and Medicine, Princeton, N.Y., 1954. Dr. Fletcher concludes on pp. 60-61: "By way of summary, we may say that in general we can validly assert our right as patients to know the medical facts about ourselves. Several reasons have been given for it, but perhaps the four fundamental ones are: first, that as persons our human, moral quality is taken away from us if we are denied whatever knowledge is available; second, that the doctor is entrusted by us with what he learns, but the facts are ours, not his, and to deny them to us is to steal from us what is our own, not his; third, that the highest conception of the physician-patient relationship is a personalistic one, in the light of which we see that the fullest possibilities of medical treatment and care in themselves depend upon mutual respect and confidence, as well as upon technical skill; and fourth, that to deny a patient knowledge of the facts as to life and death is to assume responsibilities which cannot be carried out by anyone but the patient, with his own knowledge of his own affairs. . . ." See 31 N.Y.U.L. Rev. 1157 (1956) for the report of a symposium discussing this and other topics contained in Dr. Fletcher's provocative book.

82. 251 Minn. 427, 88 N.W.2d 186 (1958).

83. This operation involves a partial excision of the prostate gland performed through the urethra.

This discussion will be limited to a consideration of the legal procedures as reported in the cases and will not attempt to weigh the "right" or moral considerations inherent in the problem.[41]

In Kemp v. [illegible],[42] the plaintiff gave his consent to the defendant surgeon to perform a [illegible] operation.[43] During the course of the operation the [illegible], removing his [illegible]. It was the plaintiff's contention that nothing had

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41. For a discussion of the moral viewpoint see Fletcher, Morals and Medicine, Princeton, N.J., 1954. Dr. Fletcher concludes on pp. 97-98: "By way of summary, we may say that in general we can validly assert our right as patients to know the medical facts about ourselves. Several reasons have been given for it, but perhaps the four fundamental ones are these: first, that as persons [illegible] moral quality is taken away from us if we are denied [illegible]; second, that [illegible] by us also [illegible], but the facts are ours, not his, and to deny them [illegible] what is our own, [illegible]; third, that the [illegible] of the physician-patient relationship [illegible] the [illegible] of medical [illegible] and [illegible] upon mutual [illegible] and confidence, [illegible]; and fourth, that to [illegible] a patient [illegible] of [illegible] life and death [illegible] which cannot be [illegible] by anyone but the patient, [illegible] of his own [illegible]. . . ." [illegible]

42. [illegible] Minn. 467, [illegible] N.W.2d [illegible] (19[illegible]).

43. This operation involves a partial excision of the prostate gland performed through the urethra.

been said concerning the fact that he would be rendered sterile by the operation, consequently the treatment was unauthorized and amounted to an assault. The Supreme Court of Minnesota held that, in the absence of an immediate emergency, the patient should have been informed before the operation that if his spermatic cord were partially removed it would result in his sterilization, and he should also have been advised that if this were not done there would be a possibility of dangerous infection. The court concluded that the question of whether he consented to the operation actually performed should have been submitted to the jury. The case recognizes that the patient must be made aware of the contingencies involved and given a free choice to determine what should be done with his body.

In a recent Missouri case, the plaintiff alleged that the defendants, a psychiatrist and his associates, were negligent in not informing him of the danger involved in combined electro-shock and insulin subcoma therapy for emotional illness. The plaintiff sustained several fractures during the course of the treatment. The appellate court in ordering a new trial on the ground that the jury instructions were misleading, stated:

> In the particular circumstances of this record, considering the nature of Mitchell's illness and this rather new and radical procedure with its rather high incidence of serious and permanent injuries not connected with the illness, the

> doctors owed their patient in possession of his faculties the duty to inform him generally of the possible serious collateral hazards; and in the detailed circumstances there was a submissible fact issue of whether the doctors were negligent in failing to inform him of the dangers of shock therapy.[84]

The most exhaustive discussion of the rule requiring an informed consent, including a discussion of the foregoing precedents, is found in the two opinions of Natanson v. Kline.[85] In this case the plaintiff sued a radiologist, alleging that she had suffered injuries as a result of cobalt radiation therapy where the hazards had not been explained to her prior to treatment. The plaintiff appealed an adverse finding by the lower court and, in ordering that the case be retried, the appellate court in its first opinion set forth the prevailing view as follows:

> In our opinion the proper rule of law to determine whether a patient has given an intelligent consent to a proposed form of treatment by a physician was stated and applied in Salgo v. Leland Stanford, Jr. Bd. Trustees, supra. This rule in effect compels disclosure by the physician in order to assure that an informed consent of the patient is obtained. The duty of the physician to disclose, however, is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances. How the physician may best discharge his obligation to the patient in this difficult situation involves primarily a question of medical

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84. Mitchell v. Robinson, 334 S.W.2d 11, 19 (Mo. 1960).

85. 186 Kan. 393, 350 P.2d 1093 (1960); opinion clarified 187 Kan. 186, 354 P.2d 670 (1960).

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> judgment. So long as the disclosure is sufficient to insure an informed consent, the physician's choice of plausible courses should not be called into question if it appears, all circumstances considered, that the physician was motivated only by the patient's best therapeutic interests and he proceeded as competent medical men would have done in a similar situation.[86]

The courts in Mitchell and Natanson were obviously motivated in their holdings by the high degree of risk involved in the treatment, however, the principles of law set forth in the opinions could give new impetus to those interested in finding new causes of action; i.e., negligence actions based upon uninformed consent.[87] The fear raised by these two cases has been somewhat tempered by subsequent decisions. In DiFilippo v. Preston,[88] the court held there was no duty imposed on a surgeon who performed a thyroidectomy to warn the patient of possible injury to laryngeal nerves where it was not the practice of surgeons in the area to warn of such possible injuries. The general rule was recently tested again in Govin v. Hunter,[89] where the plaintiff alleged

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86. Id. at 409-410, 350 P.2d at 1106.

87. For a critical discussion of the trend toward a more informed consent see Note, Malpractice--Physician Has a Duty To Inform Patient of Risk Inherent in Proposed Treatment, U. Pa. L. Rev. 768 (1961) and Oppenheim, Informed Consent to Medical Treatment, 11 Clev.-Mar.L. Rev. 249 (1962).

88. 173 A.2d 333 (Del. 1961).

89. 374 P.2d 421 (Wyo. 1962).

16. See, e.g., 429 F.2d at 1106.

17. See a similar discussion in the three-judge court's opinion in [illegible]

18. 373 F.2d 633 (2d Cir. 1967).

19. 376 F.2d 523 (5th Cir. 1967).

she should have been advised that the recommended operation for relief of her varicose veins would entail multiple incisions and additional scars and disfigurement of the leg, and that such failure of the doctor to fully apprise her constituted malpractice. The court followed Natanson as to a duty to reveal any serious risks, e.g., "We realize that under certain circumstances a physician has a duty to reveal any serious risks which are involved in a contemplated operation . . .";[90] however, the court followed DiFilippo in determining if the circumstances of the case required an explanation to the present plaintiff, e.g., "Whether or not a surgeon is under a duty to warn a patient of the possibility of a specific adverse result of a proposed treatment depends upon the circumstances of the particular case and upon the general practice followed by the medical profession in the locality . . . ."[91] The court went on to point out that the custom of the medical profession to warn patients of possible adverse effects of proposed treatment must be established by expert testimony.

Another fairly recent case has added a new dimension to the doctor's dilemma regarding informed consent, i.e., too much information may constitute a cause of action. In Ferrara v. Galluchio,[92] a patient developed "cancerophobia"

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90. Id. at 423.
91. Id. at 424.
92. 5 N.Y.2d 16, 152 N.E.2d 249 (1958).

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40. Id., at 187.

41. Id., at 188.

42. [illegible] 125 F.2d 1 (1942).

when a dermatologist told her that X-ray burns on her shoulder might be cancerous and she should have the burns examined every six months. She was allowed to recover for mental anguish flowing from the "cancerophobia." The court realized its departure from previous precedent when it remarked, "This case is somewhat novel, of course, in that it appears to be the first case in which a recovery has been allowed against the wrongdoer for purely mental suffering arising from information the plaintiff received from the doctor to whom she went for treatment of the original injury."[93] This case should not deter military practitioners from giving complete information to their patients as it seems to stand alone.

FRAUD

Consent to medical treatment obtained by fraud is defective. The case most often cited as precedent for this rule is a case with a most unique and bizarre factual situation. The case is Hobbs v. Kizer.[94] A surgeon prevailed upon a lady patient to engage in sexual intercourse, whereupon she became pregnant. Upon breaking the news to the surgeon, he examined her and assured her that she was mistaken and was really suffering from an abscess

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93. Id. at 21, 152 N.E.2d at 252.

94. 236 Fed. 641 (8th Cir. 1916).

of the vagina. She later consented to "an operation," and he took the opportunity to perform an abortion. She alleged that the abortion was without her knowledge or consent. The court held that because of the fraud the consent was defective and the plaintiff could recover damages.[95]

COERCION

The amount of force or coercion that may lawfully be employed in treating military patients is the subject of a subsequent chapter, however, the term coercion has gained a place in a general discussion of consent to medical treatment because of the case of Meek v. City of Loveland.[96] Mr. Meek brought action for damages against several city officials as a result of having his leg amputated against his will by one of the defendants. The injury that led to the amputation was caused by a shot fired by a city policeman who mistook Meek for a burglar. The court held that the defendants should not be permitted to avoid liability where the evidence revealed that Meek had been taken by force to the county poor farm (or hospital); had been refused a request to be treated at a hospital of his own selection; and had been operated on against his will.

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95. This rule is also expressed in the quote from Knowles v. Blue, supra page 29.

96. 85 Colo. 346, 276 Pac. 30 (1929).

MISTAKE

A patient might willingly permit a touching by a doctor and the doctor might administer skillful treatment, where in fact the parties didn't have a meeting of the minds as to what was taking place; consent of the patient in such a situation would be defective if there was a mistake.

In Gill v. Selling,[97] the defendant took a blood sample from the plaintiff and instructed her to return to his office in five days for a report. When the plaintiff arrived for the report, she was confused with another of the defendant's patients and taken to the operating room where she was told, "we are going to give you a test something like a blood test." The plaintiff thinking it was a continuation of the previous treatment willingly got on the operating table. The defendant, not realizing who was on the table, made a spinal test by inserting a hypodermic needle and withdrawing some spinal fluid. The test was performed in a skillful manner. The court held that the consent was defective because of the mistake.

INCAPACITY

As a general rule the consent of minors and incompetents is defective because they lack the legal capacity to

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97. 125 Ore. 587, 267 Pac. 312 (1928).

47. 158 Iowa 237, 241 N.W. 1121 (1913).

consent. It has already been noted that this rule is inapplicable in emergencies,[98] and it is concluded that the rule concerning minors is inapplicable to minors serving in the armed forces.[99]

Minors

There are exceptions to the general rule stated above. Some courts have held that the consent of a minor is sufficient if he or she is mature enough to understand the nature and import of the contemplated treatment. In Lacey v. Laird,[100] the court held that an eighteen year old minor could consent to a simple operation involving plastic surgery on her nose. In Gulf & Ship Island R.R. v. Sullivan,[101] a seventeen year old boy was held to have had the capacity to consent to "a very simple operation," i.e., a smallpox vaccination, where it appeared that the boy had sufficient intelligence to know what he was doing. In

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98. Luka v. Lowrie, supra note 55 (minors); Pratt v. Davis, supra note 59 (incompetents).

99. A discussion, with citation of authority, of this conclusion will be found in Chapter V, infra.

100. 166 Ohio St. 12, 139 N.E.2d 25 (1956).

101. 155 Miss. 1, 119 So. 501 (1928).

Bishop v. Shurly,[102] a nineteen year old boy entered a hospital for a tonsillectomy and expired after a local anaesthetic was given to him. His mother had specified a general anaesthetic, but the boy on reaching the operating room requested and was given a local. The court held the boy's instructions were not defective; the court reasoned that since the boy was legally qualified to contract for medical services as one of the necessities of life, he had the capacity to consent to the use of a local anaesthetic.

The appellate court in Bonner v. Moran[103] felt that a fifteen year old boy had not reached the degree of maturity that would render him capable of acting as a voluntary blood and skin donor for a plastic surgery procedure without the consent of his parents. The court must have been influenced by the fact that the operation was for the benefit of another person, however, it is doubtful if this was the controlling factor as a fifteen year old would have a hard time completely understanding the nature and import of such a procedure.

As a corollary to the rule that minors lack the capacity to consent is the rule that minors do not have the capacity to give legally binding instructions. In

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102. 237 Mich. 76, 211 N.W. 75 (1926).

103. 126 F.2d 121 (D.C. Cir. 1941).

Ollet v. Pittsburg, C. C. & St. L. Ry.,[104] a seventeen year old boy expressly stated he did not want his foot amputated by anyone other than his own doctor. His foot had been injured by a train whose crew took him to a hospital. While in the hospital his foot was amputated by a strange doctor. The court, in denying recovery against the defendant railroad, seemed to hinge its opinion on the emergency nature of the operation; however, since the boy was conscious and rational, it was not an emergency as defined previously in this discussion unless the boy was so immature that he lacked the capacity to consent. The court in effect stated that the doctor was not bound by the boy's instructions.[105]

In view of the foregoing holdings, it appears that the practitioner must acquire the consent of a parent or guardian of a nonmilitary minor before he can rest assured that the minor's consent is not defective. If the minor is fifteen years old or older, then his consent should also be acquired. There are no reported cases indicating that the consent of both parents is required. If the parents are legally separated or divorced, consent should be obtained from the parent having lawful custody of the child. Where the minor has a legal guardian, then the consent of the guardian would be required. If the minor

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104. 201 Pa. 361, 50 Atl. 1011 (1902).

105. Additional cases on this point are cited in note 26, supra.

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[107] Constitutional issues in this period are dealt in more in depth.

[108] See Pa. Const. of 1874, Art. XVII (1968).

does not live with his parents and has no legal guardian, then someone standing in loco parentis would have to consent, e.g., a close relative or head of an institution in which the minor lives.[106]

The law protects the parents' right to custody and control of their children,[107] consequently a very difficult problem arises when a minor needs medical attention and the parents refuse their consent. Some states have statutes authorizing the juvenile court to order necessary medical and surgical care in these cases,[108] and many courts assert jurisdiction over these situations on the theory that minors in need of medical treatment are "neglected."[109] Some courts, however, have been reluctant to override the will of the parents.[110] The courts appear to weigh the seriousness of the child's condition against the danger of the operation in determining whether to interfere.[111]

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106. Plante & Shartel, The Law of Medical Practice 25 (1959).

107. In re Frank, 41 Wash.2d 294, 248 P.2d 553 (1952).

108. E.g., Mich. Stat. Ann. §27.3178 (598.2) (b) (1) (1953).

109. E.g., In re Rotkowitz, 175 Misc. 948, 25 N.Y.S.2d 624 (1941); People ex rel Wallace v. Labrenz, 411 Ill. 618, 104 N.E.2d 769 (1952).

110. E.g., In re Frank, supra note 107; In re Seiferth, 309 N.Y. 80, 127 N.E.2d 820 (1955).

111. E.g., Morrison v. State, 252 S.W.2d 97 (Mo. 1952).

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106. Tapia v. Guerrero, 100 Cal. 2d Appeal Dispatch 295 (1950).

107. In re Perez, 61 Cal.2d 340, 340 P.2d 551 (1959).

108. [illegible] Cal. Civ. Proc. Ann. §37.112 (1954) (1961).

109. [illegible] In re Estate of [illegible], 172 Cal. App. 2d 8,7.1.34
[illegible] People ex rel Watkins v. Superior
Ct. 111, 211, 188 P.2d 7.32 (1948).

110. [illegible] In re [illegible], 6 Cal.2d 700 (1950).

111. [illegible] Nielsen v. Kinney, 164 Cal.App.2d 17 (Dec. 1958).

A military practitioner's best protection in treating minors is a properly executed Standard Form 522.[112]

Incompetents

A person who is deemed in law to be non compos mentis does not have the capacity to consent to medical treatment. As in the case of minors, consent by such a person would be defective. Except for military patients and emergency situations, the consent of the person standing in the position of guardian is absolutely required before treatment can be legally administered to incompetents;[113] guardians include parents, spouses, or those legally appointed to act for the incompetent. If an adult patient is not mentally deranged to the extent that he is unable

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112. Standard Form 522, Authorization for Administration of Anesthesia and for Performance of Operations and Other Procedures, Revised June 1961. The official function of this form is stated to be, "To obtain authorization for the administration of anesthesia, the performance of operations or other procedures, and the disposal of tissues or parts which may be removed. This form is required for dependents, veterans, or other non-active-duty military personnel but shall not be used for active-duty military personnel." [Hereafter cited as Standard Form 522.]

113. E.g., Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906); Bishworth v. Moss, 222 S.W. 225 (Tex.Com.App. 1920); Lester v. Aetna Casualty & Surety Co., 240 F.2d 676 (5th Cir. 1957); See also Army Reg. No. 40-3, para. 15b (4) (5) (6) (Mar. 1962) [hereafter cited as AR 40-3].

to understand the nature, purpose, and risks incident to a proposed treatment, he is not a *non compos mentis* and his consent would not be defective.[114]

The problems of commitment, restraint, disposition, and determining the degree of competency of mental patients and all problems dealing with the criminally insane are beyond the scope of this discussion.

Each armed force has a directive giving express authority to perform "emergency" diagnostic measures, treatment, or surgery upon military incompetents,[115] however, the word "emergency" is not defined. Again as in the case of minors, a military practitioner's best protection in treating incompetents is a properly executed Standard Form 522.

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114. *Cf.* AR 40-3, para. 60 *d*.

115. Army: Army Reg. No. 600-20, para. 48a (July 3, 1962) [hereafter cited as AR 600-20]; Air Force: U. S. Dept. of Air Force, Air Force Manual No. 160-20, Administration of Medical Treatment Activities, para. 4-34 (June 1961) [hereafter cited as AFM 160-20]; Navy: Gen. Order No. 3, Navy Dept., para. 2d (Nov. 22, 1944) [hereafter cited as Gen. Order No. 3, Navy Dept.].

Illegal Operations

A person cannot give a valid consent to an illegal act, consequently such consent is defective. Some states have statutes making it a crime for physicians to sterilize normal persons for any reason other than a therapeutic necessity[116] and all states have statutes making non-therapeutic abortions illegal.[117] Consent by the patient to any of these acts would not be a defense to the physician or surgeon,[118] but some jurisdictions hold that these operations, being morally and legally wrong, may not be the basis of a civil action by either the surgeon or the patient.[119]

The Navy specifically forbids experimental studies of a medical nature on members of the naval establishment

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116. E.g., Conn. Gen. Stat. Ann., tit. 53 §33 (1958).

117. Abortions are also an offense under Art. 134, Uniform Code of Military Justice (10 U.S.C. §934) (1958) [hereafter cited as UCMJ]; United States v. Woodard, 17 CMR 813 (1954).

118. E.g., Hancock v. Hullett, 203 Ala. 272, 82 So. 522 (1919).

119. E.g., Szadiwicz v. Cantor, 257 Mass. 518, 154 N.E. 251 (1926); Hunter v. Wheaton, 53 App.D.C. 206, 289 Fed. 604 (1923).

[illegible] Conventions

[illegible] assumed that a valid approach to [illegible] ...

[illegible] ... [illegible] ... [illegible] ... [illegible] ...

[illegible] ... [illegible] ... [illegible] ... [illegible] ...

[illegible] ... [illegible] ... [illegible] ...

without prior approval of the Secretary of the Navy.[120] Accordingly, consent without the approval of the Secretary would be defective. The author has been unable to locate any state statutes on the subject of patient experimentation but any forced experiments would undoubtedly be illegal.[121] Reasonable medical experiments performed with the consent of one having the capacity to consent would generally not be defective.[122]

Marriage

Marriage does not affect the capacity to consent. A person who is married and otherwise competent does not have to get the consent of their spouse in order to receive medical treatment. This rule applies equally between husbands and wives and extends to all types of treatment and operations. In Rosenberg v. Feigin,[123] the wife

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120. U.S. Dept. of Navy, Manual of the Medical Department, art. 1-11 (1952).

121. See 2 Trials of War Criminals Before the Nuremburg Military Tribunals 181-82 (1947) (Medical case).

122. For a good discussion of the problem of "experimentation" see McCoid, The Care Required of Medical Practitioners, 12 Vand. L. Rev. 549, 581 (1959). For a good discussion of the case law on the same subject see Smith, Antecedent Grounds of Liability in the Practice of Surgery, 14 Rocky Mt. L. Rev. 233, 266 - 273 (1942).

123. 124 Cal.App.2d 783, 260 P.2d 143 (1953).

[illegible] [illegible] [illegible] [

consented to treatment that resulted in a miscarriage. The husband sued the defendant doctor alleging that the doctor's failure to get his consent amounted to malpractice. The court held that the consent of the wife alone was sufficient. In Kritzer v. Citron,[124] the court held that the wife alone had the capacity to consent to an operation which rendered her incapable of further childbearing.

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124. 101 Cal.App.2d 33, 224 P.2d 806 (1950).

CHAPTER IV

CONSENT AND THE UNCOOPERATIVE MILITARY PATIENT

The foregoing discussion represents the general law regarding consent to medical treatment. It is the purpose of the remainder of this discussion to focus attention upon certain problems created when an attempt is made to apply the foregoing rules to a situation where a military patient doesn't desire medical attention.

Most servicemen are more than eager to receive all the medical assistance to which they are entitled as members of the armed forces, and consent to treatment is never mentioned as it is simply implied from the circumstances. In these routine situations the military practitioner is guided by the general rules of consent. However, a very real "medico-military-legal problem" arises when a serviceman does not exhibit such an eagerness and absolutely refuses to permit any medical, dental or surgical procedure to be performed upon him. It is a problem for the service practitioner as he doesn't want to become involved in either a civil or criminal malpractice action that would damage his professional standing both as a doctor and as an officer. It is a problem for the military commander as he is responsible for the discipline, welfare and morale of those serving under his command. The law

is put to a severe test as it must strike a balance between the personal rights of the patient and the needs of the military, while at the same time guiding and protecting those with command responsibilities.

FORCED SURGERY[125]

The Congress and the President have never expressly stated their views on the amount of force that can be used to treat or operate upon, without their consent, those subject to military authority and control. As a result, the armed forces have been left to pursue their own courses on these uncharted waters.

The positions taken by the armed forces and the writers on the subject under discussion are set forth in this chapter; however, the views, conclusions and recommendations of the author are located in the final chapter of the text.

The Military Position

There is no single military position as each armed force has been permitted to seek its own solution to the

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125. The word "surgery" is used in the remainder of this study to mean an operation where an excision or incision is made to any of the body's organs or parts.

problem.

The Navy is the only armed force that has a definite policy with regard to all forced surgery. This policy applies both in time of war and time of peace and reads as follows: "As a matter of policy, surgery shall not be performed on a person over his protest if he is mentally competent. This does not mean that he should not be subjected to disciplinary action for refusal to submit to surgery if his refusal is determined to be unreasonable."[126]

The Army, except for emergency surgery on psychotics, does not have a definite policy relating to forced surgery set forth in its basic directive. The Army's general personnel regulation provides for a board procedure and disciplinary action when a man refuses surgical treatment but is completely silent on whether the recommended surgery can be performed by force.[127] The Army is presently considering a change to its regulation that would clarify its position. A proposed draft reads in part as follows:

> 48. Medical Care. a. General. A member of the Army on active duty or active duty for training usually will be required to submit to medical care considered necessary to protect or maintain the health of others, to preserve the member's life, or to

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126. Gen. Order No. 3, Navy Dept., para. 7.

127. AR No. 600-20, para. 48a.

prevent or alleviate undue suffering by the member.

b. Medical care, as used in this paragraph means preventive, diagnostic, therapeutic and rehabilitative medical, surgical, psychiatric and dental procedures.

c. Under the following circumstances medical care may be performed with or without the member's permission:

(1) Emergency medical care which is required to preserve the life or health of the member.

(2) Medical care that is necessary to protect the life or health of a member who has been declared by a qualified psychiatrist to be mentally incompetent.

(3) Routine medical care for minor or temporary disabilities. . . .[128]

The Judge Advocate General of the Army appears to have traditionally taken a position sanctioning the use of force where a serviceman refuses recommended surgery, however, the opinions on the subject seem to have purposely avoided being concise.[129]

The Air Force has a definite policy only with regard to forced surgery in emergencies; it reads as follows:

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128. For a discussion of the background and a complete text of this proposal, see JAGA 1963/3380 (Jan. 10, 1963). (Emphasis added.)

129. See, e.g., JAGA 1951/2300 (Mar. 16, 1951); JAGA 1951/4171 (Jul. 10, 1951); JAGA 1955/8356 (Oct. 24, 1955). See Schiller, Military Law, p. 94 (1952) for a 1918 opinion.

"When emergency treatment, surgery, or diagnostic procedure is required to preserve the life or health of the patient, it may be performed with or without his permission. The same is true when a diagnostic procedure or treatment is necessary to protect the life or health of a patient who has been declared by a qualified psychiatrist to be mentally incompetent."[130] The Air Force then is the only armed force with a definite policy sanctioning the use of some forced surgery.

The Writers' Position

This author was only able to locate writers who take the unqualified position that force is always authorized when a serviceman refuses recommended surgery. One author phrased the question and gave his answer as follows:

> Does a person in the military service possess the right stated in the Pratt case, "the right to the inviolability of his person, the right to himself"? Can he be operated upon without his consent?
>
> To reach a logical as well as a legal answer to these questions, the basic duty of military personnel must be borne in mind. Every soldier, sailor, airman and marine has a duty to maintain himself in the best possible physical condition to perform the military tasks that are required of him, whether in the preparation for the defense, or in the actual defense of the United States. Diagnosis and corrective medical treatment play an important part in maintaining military manpower at the proper efficient level. If a serviceman were permitted to decide for himself that he

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130. AFM 160-20, para. 4-34.

> would not have a needed operation and thereby make himself unavailable for military duty, the ability of the Armed Services to maintain military strength at peak efficiency would be seriously impaired. Thus, in the case of military personnel, the rule is that consent is not necessary in order to perform an operation.[131]

The above author left no doubt as to what he meant by the word operation as he quoted the following definition from the third edition of Black's Law Dictionary:

> In surgical practice, the term is of indefinite import, but may be approximately defined as an act or succession of acts performed upon the body of a patient, for his relief or restoration to normal conditions, either by manipulation or the use of surgical instruments or both, as distinguished from therapeutic treatment by the administration of drugs or other remedial agencies.[132]

Another writer, in summing up the exceptions to the general rule that consent must precede surgical treatment, stated:

> An exception to the consent rule is founded on emergencies. . . .
>
> Another exception is founded on military expediency. Every officer and airman has a duty to maintain himself in the best possible physical condition to perform his military duties. Thus in the case of military personnel, consent of the patient is unnecessary in order for a military

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131. Marchus, Medical Malpractice, Hospital Negligence and the Armed Services at 68-69 (May 1957) (unpublished thesis presented to The Judge Advocate General's School, U. S. Army). (Emphasis added.)

132. Id. at 56.

> medical surgeon to perform an operation on him. Nevertheless, whenever possible it would appear to be the most prudent practice to obtain written consent from the patient, be he military or civilian.[133]

Universal Military Training and Service Act[134]

It is felt that this study would be incomplete without a consideration of the treatment given to registrants under the Universal Military Training and Service Act who have remediable physical defects. The act provides that, "the President is also authorized, under such rules and regulations as he may prescribe, to provide for the deferment from training and service in the Armed Forces . . . of any or all categories of those persons found to be physically, mentally, or morally deficient or defective."[135] Pursuant to this authority the President by executive order has set forth a list of "disqualifying obvious defects and manifest conditions":[136]

> The existance of one or more of the obvious defects or manifest conditions contained in the following alphabetical list shall disqualify

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133. Rakestraw, Malpractice and the Military Doctor, U. S. Air Force JAG Bull., Nov. 1961, p. 7.

134. 50 U.S.C. §§451-73 (1948).

135. 50 U.S.C. §456(h) (1948).

136. 32 C.F.R. §1629.1 (1962).

> a registrant for service in the armed forces if the functional ability of the registrant is impaired to the extent that he cannot perform military duties in a satisfactory manner: [The two page list includes such defects as a type of inguinal hernia, several types of tumors, and certain weight conditions.]

Those who are obviously unfit for military duty due to physical defects are classified "IV-F" by their local draft board; all others, unless they are qualified for an exemption, are ordered to an armed forces examining station for a complete physical examination. Upon discovery of an aforementioned "disqualifying obvious defect, etc." the person is rejected; however, if he has only a temporary defect he is dealt with as follows:

> For registrants disqualified for defects that are temporary, such as remediable defects, . . . an appropriate comment will be entered . . . [on certain forms] to indicate that a reexamination may be justified at a later date. It is the prerogative and responsibility of Selective Service local boards to determine if such individuals should be returned for a second examination; therefore, the comment [by the army examiners] will not recommend, request, or suggest such action . . . .[137]

It clearly appears from the above that the present policy is not to accept persons with remediable defects with a view toward having the military correct them either willingly or by force. Since nothing is mentioned concerning treatment when he reports back to his local board,

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137. Army Reg. No. 601-270, para. 60(c)(4)(Sept. 12, 1962).

presumably he is under no duty or obligation to remedy the defect and doesn't have to worry about military service as long as he retains the defect.

FORCED MEDICAL AND DENTAL TREATMENT

The term "medical treatment" does not ordinarily include "surgery" within its meaning. It must be concluded from the plain language of their basic directives[138] that the armed forces give "surgery" a meaning apart from the term "medical treatment," e.g., the Army's directive is entitled "Refusal of medical, surgical, or dental treatment"; the Navy's is entitled, "Disposition Of Naval Personnel Who Refuse Medical, Dental Or Surgical Treatment . . ."; and the Air Force in the text of its directive states, "a medical board will examine any person in the military service who refuses to submit to medical treatment, surgical operation, or diagnostic treatment."

Medical treatment will be used in this discussion to mean all steps, excluding surgery and transfusions, taken to effect a cure of an injury or disease, including examination and diagnosis as well as application

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138. These directives are set forth in note 115, supra.

of remedies. Dental treatment could be defined in the same manner by simply limiting the scope of the cure to the teeth; therefore, dental treatment will be treated as a part of the broader term medical treatment.

The Military Position

The President by executive order has set forth the duties of the medical officer as follows:

> It is the duty of medical officers to attend sick members of the armed forces, to make periodical physical examinations as required by regulations and to examine persons for enlistment, and medical officers may be specially directed to observe, examine, or attend a member of the armed forces. Such observation, examination, or attendance would be official . . . .[139]

The Navy expressly sanctions the following measures "without the consent and over the protest of the individual concerned":

> (a) Administer authorized immunization and prophylactic measures for the prevention of disease
>
> (b) Proceed with routine diagnostic measures and other special tests and examinations except in those cases where for any reason the procedure would entail unreasonable risk of injury or by its nature be difficult of performance without the patient's voluntary cooperation. The practice contemplated may be illustrated by the examples noted below.
>
> (Compulsion permissible--examples: Kahn and Bogen tests, ordinary X-rays, dermal reaction tests, lumbar puncture, taps of body fluids, catheterization,

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139. U. S. Dept. of Defense, Manual for Courts-Martial United States 1951, para. 151c(2). [hereinafter cited as MCM, 1951].

electroencephalography, ordinary physical examination, etc.).

(Compulsion not permissible--examples: Exploratory surgery, surgical biopsy, introduction of lipiodol into spinal canal, bronchoscopy, cystoscopy, ventriculography, presence of substantial contraindications arising from idiosyncrasy or poor condition of patient, etc.).

Refusal of these measures may, however, be unreasonable under the tests specified in paragraph 5 and so constitute a breach of discipline.

(c) Administer usual and customary medical or dental treatment for contagious or communicable diseases.

(d) Perform emergency surgery necessary to protect health or life if the patient is mentally incompetent from psychiatric causes or from the effects of his disease or condition.[140]

The Army does not have a stated policy in its basic directive regarding forced medical treatment, however, its basic directive does provide that, "immunizations that conform to established medical practice may be administered forcibly to those refusing same. . . ."[141]

The Air Force in its basic directive authorizes forced "emergency treatment," however, this term is not defined and nothing is mentioned concerning the use of force in performing routine treatment or conducting routine physical examinations.[142]

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140. General Order No. 3, Navy Dept., para. 2.

141. AR 600-20, para. 4b.

142. AFM 160-20, para. 4-34.

REFUSAL TO SUBMIT TO SURGERY OR TREATMENT AS A BREACH OF DISCIPLINE[143]

Each armed force takes the position that refusal to obey an order to submit to reasonable surgery or medical treatment is a court-martial offense. Notice has already been taken of the fact that there are no reported courts-martial for this offense since the adoption of the Uniform Code of Military Justice, however, trials did occur prior to the adoption of the present code.[144]

Each armed force requires that those who refuse treatment, surgery, or physical examination must appear before a medical board before they can be tried by court-martial. In the Army and Air Force the board must answer the following questions in the affirmative before trial by court-martial is considered appropriate: 1) Does the patient need the treatment in order to properly perform his military duties? 2) Can the treatment normally be expected to produce the desired results? The Navy requires its boards to answer similar

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143. All references to policies and procedures in the following paragraphs are taken from the basic directive of each armed force on the subject of refusal to consent to medical treatment. These directives are set forth in note 115, supra.

144. See, e.g., CM 242014, Moore, 26 BR 377 (1943).

[illegible]

[illegible]

[illegible]

inquiries and demands answers to the following additional questions before a trial for refusing surgery is considered appropriate: 1) Is the proposed surgery an established procedure that qualified and experienced surgeons would ordinarily recommend and undertake? 2) Considering the risks ordinarily associated with surgical treatment, the patient's age and general physical condition, and his reasons for refusing treatment, is the refusal reasonable or unreasonable?

The Army and Navy require review of the board's findings by higher authority before a court-martial can be ordered; the position of the Air Force concerning review by higher authority cannot be determined from its directive.

The present Manual for Courts-Martial has a sample specification under the charge of Article 92, Uniform Code of Military Justice relating to "failure to obey lawful order to submit to certain medical treatment,"[145] consequently such an offense today would be charged under that article.

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145. MCM, 1951, app. 6c(29).

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

It behooves military medical practitioners to fully understand the legal requirements of consent, as failure to observe these requirements might be grounds for criminal prosecution or a civil suit for damages. Those in command, because of their overall responsibility, should likewise be familiar with these requirements. Therefore, these requirements should be set forth in regulations that are easily understandable and readily available.

The ordinary doctor-patient relationship remains unchanged between a service doctor and a dependent patient, however, certain aspects of this relationship are changed by having the patient subject to military authority and control. For purposes of morale, military patients should generally be accorded all consensual rights and privileges of ordinary patients, notwithstanding any change in the doctor-patient relationship and the fact that certain treatment could be legally given to them without their consent.

Many disagreements could be prevented by acquiring express consent from patients rather than relying on implied consent; any doubt should always be resolved in

favor of getting express consent.

Although oral consent is just as legally binding as written consent, written consent is preferred in all cases where there is any danger to the life, health, or well-being of the patient.

A uniform regulation applicable to all the armed forces should be promulgated describing when and how written consent should be acquired from those being treated by service practitioners. Paragraph (5), Army Regulations 40-3 (March 26, 1962)[146] is recommended as a working model. The following changes are proposed to this working model:

First: All the provisions except sections (a)(1)(2)(3) and (b)(7)(8) should be made applicable to military as well as nonmilitary patients.

Second: Section (d) should incorporate the definition of "emergency" set forth in Chapter II, supra and impose a duty on military practitioners to render treatment in all emergency cases except those discussed in the following paragraph.

Third: The last line of the present section (d) should be changed to read as follows: "Where parents, guardians, or legal representatives are reasonably

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146. This regulation is set forth as Appendix A.

favor of existing judicial economy.

Although [illegible] is [illegible] applying an [illegible] analysis, courts [illegible] to [illegible] where there is any [illegible] to the [illegible] [illegible] of the parties.

A motion [illegible] [illegible] [illegible]

available but object to necessary treatment of mental incompetents or nonmilitary minors, such treatment will be withheld pending notification of and instructions from the proper civilian authorities. Contact with the civilian authorities will be established in the most possible expeditious means." This change is only proposed as an interim measure, as it is recommended that a detailed study be made to determine if federal legislation is needed or desired, under these circumstances, to better protect the rights and interests of those that would be involved.

Fourth: A paragraph should be added to section (a) pointing out that military minors are emancipated to the extent that their consent is legally binding without the consent of their parents. Although there are no statutes or reported cases directly in point, it has long been established that a minor serving in the armed forces becomes emancipated from the control of his parents for many other purposes.[147] In the leading case on point,

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147. See, e.g., 39 Am. Jur. Parent & Child, §64 (1942). Marchus, supra note 131 at 71-72 shares the view of the author that consent of a military minor, without the consent of his parents, is not defective.

many other persons.[12] In the Dowling case we judged
[illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible]

the Supreme Court expressed the view that:

> Enlistment is more than a contract; it effects a change of status. It operates to emancipate minors at least to the extent that by enlistment they become bound to serve subject to rules governing enlisted men and entitled to have and freely to dispose of their pay. Upon enlistment of plaintiff's son . . . he became entirely subject to the control of the United States in respect of all things pertaining to or affecting his service.[148]

Standard Form 522 needs amending in order to insure an "informed" consent. The practitioner should be required to indicate over his signature that he has counseled the patient concerning the nature, risks, and expected results of the contemplated procedures; a space should be provided on the form for this purpose. This would eliminate the necessity for "annotating" the form as presently required by the Army.[149] The form, or the regulations governing its use, should make it clear that in deciding if a specific disclosure is required to insure an informed consent, the military practitioner should rely on the practice followed in the general military community rather than on the practice

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148. United States v. Williams, 302 U.S. 46, 49-50 (1937).

149. AR 40-3, para. 5b.

followed in the local civilian community.[150]

A uniform regulation applicable to all the armed forces should be promulgated setting forth all illegal treatment and operations and all treatment and operations prohibited by federal policy. This regulation should not be made dependent upon the various conflicting state laws and should apply throughout the worldwide military community. A detailed study should be made to determine the extent to which the subjects of experimentation, birth control, contraception, and sterilization should be incorporated into such a regulation; the study should treat such questions as the extent to which federal medical facilities and doctors can be utilized in performing vasectomies or other sterilization procedures on both males and females who are on active duty or in a dependent status.

The directives of the armed forces discussed in Chapter IV of this study are inadequate to protect the

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150. The fundamental reason for this recommendation stems from the fact that acceptance of the local civilian community standard would result in unacceptable variances throughout the military medical establishment. This was recognized in Kolesar v. United States, 198 F.Supp. 517, 521 (S.D.Fla. 1961) where the court stated, "such an institution [a military hospital] is a community apart and cannot be said to have contributed nothing to the standards of its geographical location or unto itself." This same view is shared by Marchus, op. cit. supra note 131, at 25.

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rights of those in the military who refuse recommended surgery.

It is the contention of this author, notwithstanding the authorities cited in Chapter IV, supra, that the patient's aforementioned right to "the inviolability of his person" is protected by Articles I and V of the Bill of Rights, and this right extends to the serviceman to the extent that in time of peace surgery can not be forced upon him without his consent.[151] The rights of the individual simply outweigh any military necessity. This contention also leads to the conclusion that any peacetime order to submit to unwanted surgery would be unlawful, as it would not be "reasonably necessary to safeguard and protect the morale, discipline and usefulness

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151. The fact that a serviceman is protected by the Bill of Rights can no longer be disputed; see, e.g., Burns v. Wilson, 346 U.S. 137 (1953). For a refreshing reassurrance of this fact, backed by liberal citation of authority, see Warren, The Bill of Rights and the Military, 37 N.Y.U.L.Rev. 186 (1962) and Quinn, The United States Court of Military Appeals and Military Due Process, 35 St. John's L.Rev. 232 (1961).

of the members" of the armed forces.[152]

It is not suggested that the patient's right to "the inviolability of his person" is absolute. Time, place, and circumstance must all be taken into account. War or grave national emergency may justify an exercise of authority affecting individual rights which are intolerable in time of peace. If this country were faced with a crisis where maximum military manpower were crucial to safeguard its very existence, then force would be authorized to perform remedial surgery and orders to submit to such surgery would likewise be lawful;[153] however, in order to insure "due process" the following would have to be affirmatively shown: 1) the surgery was required to relieve a condition that prevented the performance of military duties; 2) it

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152. The Court of Military Appeals in United States v. Martin, 1 USCMA 674, 676, 5 CMR 102, 104, (1952) formulated the following as a test for determining the lawfulness of an order: "All activities which are reasonably necessary to safeguard and protect the morale, discipline and usefulness of the members of a command and are directly connected with the maintenance of good order in the services are subject to the control of the officers upon whom the responsibility of the command rests."

153. It has already been pointed out that a sovereign power has a right to use force against a person for the protection of all. See, e.g., the cases cited in notes 27-29, supra.

was expected to be successful; 3) it was an established procedure that qualified and experienced surgeons would ordinarily recommend and undertake; and 4) it would not unduly endanger the life of the patient. When maximum military manpower becomes this crucial, a national program should be established permitting remedial surgery on all citizens eligible for military service. This would be a proper subject for coverage by the Universal Military Training and Service Act.

Physical examinations and routine medical treatment fall into a different category than surgery, consequently orders to submit to the former are lawful as they are reasonably necessary to safeguard and protect the morale, discipline and usefulness of the members of a command.[154] Since such orders are lawful, it necessarily follows that reasonable force could be employed in order to see that such orders are carried into effect.[155] However, any force applied in such a manner that would be shocking to the conscience of an ordinary person would violate the due process provision of the Constitution.[156]

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154. See United States v. Baker, 11 USCMA 313, 29 CMR 129 (1960).

155. Cf. MCM, 1951, paras. 150b, 151c(2).

156. Cf. United States v. Rochin, 342 U.S. 165 (1952); United States v. Williamson, 4 USCMA 320, 15 CMR 320 (1954) (dissenting opinion).

A uniform regulation applicable to all the armed forces should be promulgated in order to insure that the basic rights are accorded those refusing medical and surgical treatment. The regulation should establish uniform procedures to be followed and should set forth clear examples of situations where force would be authorized and examples of those situations where force would not be authorized. Such a regulation should outlaw forced surgery, at least until a national program is established on the subject, and should provide for the discharge, with limited benefits, of those refusing remedial surgery. The regulation should provide for administrative as well as substantive due process in its procedures. The Navy Department's General Order No. 3,[157] with few exceptions, fulfills all of these requirements and is recommended as a working model. The only recommended major change to this working model, other than a change in the language to include the other armed forces, would be to remove all references permitting disciplinary action for refusing recommended surgery and insert a provision expressly prohibiting disciplinary action in such cases.

Medical and surgical treatment are considered as major fringe benefits by most servicemen. All possible

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157. General Order No. 3, Navy Dept. is set forth as Appendix B.

care should be taken to keep such treatment in the benefit category rather than making possible military medical treatment a thing to be feared. To the maximum extent possible, a military patient should be looked upon as just another patient and should be treated accordingly.

APPENDIX A

ARMY REGULATIONS No. 40-3, MEDICAL SERVICE - MEDICAL, DENTAL, AND VETERINARY CARE, PARAGRAPH 5, (MARCH 26, 1962)

5. SPECIAL CONSENT REQUIREMENTS. a. Obtaining consent. Signed consent for the performance of certain diagnostic and therapeutic procedures and under certain other circumstances must be obtained from nonmilitary patients (both inpatients and outpatients). The consent required by this paragraph should not be confused with the general implied consent procedures incident to admitting a hospital patient. Except as provided below, the patient should personally sign the consent which will be recorded on SF 522 (Clinical Record - Authorization for Administration of Anesthesia and for Performance of Operations and Other Procedures).

(1) If the nonmilitary patient is unmarried and under the age of 21, consent will ordinarily be obtained from the patient's parents or guardian.

(2) If the patient covered in (1) above is able to understand and comprehend fully the significance of the procedures contemplated, it is also desirable that the patient's consent be obtained.

(3) In any circumstances in which the securing of parental consent is considered unnecessary in view of the age, mental condition, and emancipated status of the patient, nonavailability of the parents, and similar factors, the advice of the local staff judge advocate or other legal officer should be sought.

(4) When a judicial determination of mental incompetency has been made, consent must be obtained from the individual appointed by the court to act for the incompetent patient.

(5) When the question of mental competency arises and a judicial determination of mental competency has not been made, the question of authority to consent will be referred to the appropriate judge advocate or legal adviser for advice.

(1) If the [illegible] relies upon [illegible] the [illegible] may [illegible] from the [illegible] [illegible] [illegible].

(2) If the [illegible] [illegible] in (1) above is [illegible] [illegible] [illegible]

(6) When a patient for some other reason is unable to respond, the consent of the spouse or next of kin must be obtained. In the event that the spouse or next of kin cannot be contacted, the question of authority to consent will be referred to the appropriate judge advocate or legal adviser for advice.

b. Counseling required. The physician or dentist who is to perform or supervise the performance of a contemplated procedure will counsel the patient and/or the consenting individual. Counseling will include an explanation of the nature and expected results of the contemplated procedure. The physician or dentist will annotate SF 522 to indicate that the patient and/or the consenting individual was so counseled.

c. Procedures or circumstances which require consent. The procedures or circumstances which require special consent are--

(1) All major and minor surgery which involves an entry into the body, either through an incision or through one of the natural body openings.

(2) Any procedure or course of treatment in which anesthesia is used, whether an entry into the body is involved or not.

(3) All nonoperative procedures which involve more than a slight risk or harm to the patient, or which involve the risk of a change in the patient's body structure.

(4) All procedures where roentgen ray, radium, or other radioactive substance is used in the treatment of the patient.

(5) All procedures which involve electro-shock or insulin coma therapy.

(6) All other procedures which in the opinion of the attending physician or dentist, the chief of service, or the commander require a special consent. Any question as to the necessity of obtaining a special consent from a patient should be resolved in favor of procuring the consent.

(d) [illegible]

e. [illegible]

(1) [illegible]

(2) [illegible]

(3) [illegible]

(4) [illegible]

(5) [illegible]

(6) [illegible]

(7) Admission of patients with psychotic disorders.

(8) Admission of patients to closed wards.

d. Consent in emergencies. In an emergency of any nature, which is a serious and imminent threat to the life, health, or well-being of a patient, and time does not permit obtaining the required consent, the physician may proceed with whatever measures are necessary and required. However, if the patient is a nonmilitary minor, whose parents must consent to non-emergency treatment under the rules set forth in a(1), and (2), and (3) above, treatment will not be given over the parents' expressed or implied objection even in emergency conditions.

e. Dental procedures. Consent for dental procedures which come under the provisions of c(1) and (2) above may be obtained at the time a course of treatment is started. One SF 522 may be used for a complete course of treatment.

APPENDIX B

GENERAL ORDER No. 3, NAVY DEPARTMENT, (NOVEMBER 22, 1944)

DISPOSITION OF NAVAL PERSONNEL WHO REFUSE MEDICAL, DENTAL, OR SURGICAL TREATMENT IN TIME OF WAR

1. Members of the naval service who refuse to submit to medical, dental, or surgical measures necessary to keep them fit to perform their duties shall be handled in accordance with the following directions.

2. The senior medical officer of a ship or station, after consultation with other medical or dental officers, if available, and with the approval of the commanding officer, shall, where in his judgment the best interests of the individual or of the service require, take the following measures without the consent and over the protest of the individual concerned:

(a) Administer authorized immunization and prophylactic measures for the prevention of disease.

(b) Proceed with routine diagnostic measures and other special tests and examinations except in those cases where for any reason the procedure would entail unreasonable risk or injury or by its nature be difficult of performance without the patient's voluntary cooperation. The practice contemplated may be illustrated by the examples noted below.

(Compulsion permissible--examples: Kahn and Bogen tests, ordinary X-rays, dermal reaction tests, lumbar puncture, taps of body fluids, catheterization, electroencephalography, ordinary physical examination, etc.).

(Compulsion not permissible--examples: Exploratory surgery, surgical biopsy, introduction of lipiodol into spinal canal, bronchoscopy, cystoscopy, ventriculography, presence of substantial contraindications arising from idiosyncrasy or poor condition of patient, etc.).

Refusal of these measures may, however, be unreasonable under the tests specified in paragraph 5 and so constitute a breach of discipline.

(c) Administer usual and customary medical or dental treatment for contagious or communicable diseases.

(d) Perform emergency surgery necessary to protect health or life if the patient is mentally incompetent from psychiatric causes or from the effects of his disease or condition.

3. Persons who unreasonably refuse routine medical, dental, or surgical treatment for minor or temporary

disabilities shall be reported to the commanding officer for disciplinary action. This is intended to include commonplace cases involving little or no risk to the patient where it is inexpedient and unnecessary to transfer the patient to a naval hospital. The senior medical officer, in determining whether the patient's refusal of the procedure is unreasonable, shall do so after consultation with other medical or dental officers, if available, and after due consideration of the man's condition, his reasons for refusal and such tests as those indicated in paragraph 5. Special cases may, if considered desirable, be reported to the Bureau of Naval Personnel or Commandant, United States Marine Corps, via the Bureau of Medicine and Surgery, for further instructions.

4. Members of the naval service who refuse to submit to medical, dental, or surgical procedures shall, with the exceptions noted in paragraphs 2 and 3, be transferred to a naval hospital for further observation and disposition.

5. Patients transferred to a naval hospital in accordance with these instructions shall, following their arrival at the hospital, be brought before a Board of Medical Survey consisting of not less than three medical officers who shall study the case, inquire into the merits of the individual's refusal to submit to treatment and report the facts with their recommendation to the Bureau of Naval Personnel, or Commandant, United States Marine Corps, via the Bureau of Medicine and Surgery.

(a) In surgical cases, the Board's report should contain the answers to the following questions:

(1) Is surgical treatment required to relieve the incapacity and restore the individual to duty status and may it be expected to do so?

(2) Is the proposed surgery an established procedure that qualified and experienced surgeons would ordinarily recommend and undertake?

(3) Considering the risks ordinarily associated with surgical treatment, the patient's age and general physical condition, and his reasons for refusing treatment, is the refusal reasonable or unreasonable? Here fear of surgery or religious scruples in such cases are not to be considered.

(b) If the individual concerned has refused a medical, dental, or diagnostic measure the Board of Medical Survey should answer similar inquiries designed to show need and risk of the procedure.

6. As a general rule, refusal of minor surgery should be considered as unreasonable in the absence of substantial contraindication. Cases of major surgery require most careful individual appraisal. Refusal of

such operations may be reasonable or unreasonable, according to the circumstances of the particular case. In such cases, the age of the patient, any existing physical contraindications, previous unsuccessful operations, and any special risks should be taken into consideration.

7. As a matter of policy, surgery shall not be performed on a person over his protest if he is mentally competent. This does not mean that he should not be subjected to disciplinary action for refusal to submit to surgery if his refusal is determined to be unreasonable.

8. If a Board of Medical Survey decides that a diagnostic, medical, dental, or surgical procedure is indicated, these findings must be made known to the patient and the Board's report shall show that he was afforded an opportunity to submit a written statement explaining the grounds for his refusal. If such a statement is submitted, it shall be forwarded with the Board's report. The patient should be advised by the Board at this time that his continued refusal may lead to disciplinary action. Even if his disability originally arose in line of duty, its continuance would be attributable to his unreasonable refusal to cooperate in its correction. The continuance of the disability should, therefore, be considered as due to the individual's own misconduct and as "not in line of duty" from and after the time of his unreasonable refusal.

9. If, after review by the bureaus and offices concerned, it is concluded that the individual's refusal is unreasonable, the Chief of Naval Personnel, or Commandant of the Marine Corps, in case of marines, will order trial by court martial or such other action as may be warranted.

FORRESTAL,
Secretary of the Navy.

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